

**MEDICARE SPENDING ON
POST-ACUTE CARE SERVICES:
A PRELIMINARY ANALYSIS**

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In response to a request from the House Committee on the Budget, this preliminary analysis examines the growth in Medicare spending for post-acute care services. In addition to documenting the sharp rise in Medicare outlays for services provided by skilled nursing facilities and home health agencies (the main providers of post-acute care), it briefly considers policy options that could slow the rapid growth in that spending, focusing on bundling payments for acute and post-acute care services. This analysis was prepared by Joseph Antos, Linda Bilheimer, and Pete Welch of the Congressional Budget Office's Health and Human Resources Division. In accordance with CBO's mandate to provide objective, impartial analysis, this paper contains no recommendations.

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INTRODUCTION

During the 1970s, Medicare was primarily an acute care program that paid for hospital and physician services, and relatively little care for people with more chronic conditions. Over the past 15 years, however, Medicare spending has shifted increasingly to post-acute care services, and many of those services are being provided to essentially long-term care patients.

In fiscal year 1995, Medicare spent about \$29 billion on post-acute care services provided by skilled nursing facilities (SNFs), home health agencies, and specialty hospitals including rehabilitation and long-term care facilities--all financed from the Hospital Insurance (HI) Trust Fund.¹ Post-acute care services, particularly SNF and home health care, represent the most rapidly growing component of fee-for-service spending in HI.

Rapid increases in spending for post-acute care services in the 1990s have added to the growing financing crisis facing the Medicare program. The Congressional Budget Office (CBO) projects that under current law, spending on post-acute care services will continue to grow more rapidly than total Medicare spending. This paper discusses the growth of spending for post-acute care services

1. In this paper, post-acute care services refer to all services provided by SNFs, home health agencies, and certain specialty hospitals, whether or not they are delivered soon after a patient's stay in an acute care hospital. Post-acute care services also include a portion of outpatient rehabilitation services financed by Part B.

in Medicare and the major factors contributing to that growth. Several policy options that could slow the growth of Medicare spending for post-acute care services are briefly described. The paper also includes a more detailed discussion of one of those options--bundling post-acute care services--including technical aspects of the design of a bundling proposal.

GROWTH IN MEDICARE SPENDING ON POST-ACUTE CARE SERVICES

Between 1990 and 1995, HI spending on post-acute care services grew at an average rate of 29 percent a year, compared with a rate of 11 percent for all Medicare benefits and 6 percent for acute inpatient hospital services (see Table 1).² SNF and home health services accounted for more than 80 percent of that post-acute care spending in 1995 and for 14 percent of Medicare outlays for benefits. CBO projects that spending for SNF and home health services will continue to grow faster than overall Medicare spending over the next five years, reaching \$49 billion in 2002 (see Table 2). That would be almost 16 percent of all Medicare outlays for benefits in that year.

Of perhaps greater concern to some policy makers is the increasing share of HI outlays accounted for by post-acute care services. CBO projects that spending on

2. That estimate of the growth of spending on post-acute care services excludes spending for outpatient rehabilitation services financed by Part B.

TABLE 1. SPENDING FOR MEDICARE BENEFITS, FISCAL YEARS 1990 AND 1995

Service	Benefit Payments (In billions of dollars)		Average Annual Rate of Growth (In percent)
	1990	1995	
<hr/>			
Hospital Insurance			
Post-Acute Care			
Home Health	3.3	14.9	35
Skilled Nursing Facility	2.8	9.1	27
Post-Acute Care Hospital ^a	2.2	5.4	19
All HI Post-Acute Care	8.3	29.4	29
PPS Hospital	51.6	69.2	6
Other HI ^b	5.8	14.8	21
All HI Benefits	65.7	113.4	12
All Medicare Benefits	107.2	176.9	11

SOURCES: CBO January 1997 baseline; 1996 Green Book;
Medicare National Claims History Files; and
Health Care Financing Administration, Bureau of Data Management and Strategy.

NOTE: HI = Hospital Insurance; PPS = prospective payment system.

a. PPS-exempt rehabilitation units and hospitals, and long-term care hospitals.

b. Health maintenance organizations, hospices, and certain PPS-exempt units and hospitals.

**TABLE 2. PROJECTED SPENDING FOR MEDICARE BENEFITS,
FISCAL YEARS 1996 AND 2002**

Service	Benefit Payments (In billions of dollars)		Average Annual Rate of Growth (In percent)
	1996	2002	
Hospital Insurance			
Home Health	16.7	29.9	10
Skilled Nursing Facility	11.1	19.2	10
PPS Hospital	72.7	86.1	3
Other	23.3	64.3	18
All HI Benefits	123.8	199.5	8
All Medicare Benefits	191.0	312.4	9

SOURCE: CBO January 1997 baseline.

NOTE: HI = Hospital Insurance; PPS = prospective payment system.

SNF and home health services will grow at an average rate of 10 percent a year between 1996 and 2002, accounting for one-quarter of HI benefit outlays by the end of the period.³ By contrast, spending for acute inpatient hospital services in fee-for-service Medicare will grow at an average rate of less than 3 percent over the same period (see Box 1).

Both the number of Medicare enrollees who use post-acute care services, and the amount of those services that they use, grew substantially over the 1990-1995 period. The total number of Medicare home health visits, for example, increased by about 30 percent a year between 1990 and 1995, only slightly less than the growth in outlays (see Table 3). That remarkable growth in visits was the result of a 12 percent annual growth in the number of home health users and a 16 percent annual growth in the number of visits per user. By contrast, average spending per visit (an approximation for the price of a visit) grew by only 4 percent a year, although that relatively slow growth may have been partly the result of a shift away from skilled nursing visits toward aide visits over that period.

Outlays for SNF services also soared between 1990 and 1995, rising at an average rate of 27 percent a year (see Table 4). That growth reflected a 15 percent average annual increase in the number of users of SNF services and growing

3. CBO does not make separate projections for the other post-acute care services.

BOX 1.
COMPARING THE GROWTH OF MEDICARE SPENDING ON
INPATIENT HOSPITAL AND POST-ACUTE CARE SERVICES

Comparisons between the growth of Medicare spending on inpatient hospital and post-acute care services are difficult to make. One factor dampening the future growth of spending in Medicare's fee-for-service sector is the rapid shift of beneficiaries from that sector into health maintenance organizations (HMOs). But not all services are equally affected. In particular, beneficiaries who use SNF and home health services extensively are less likely to choose to enroll in HMOs, whose coverage of those services is much more stringent. Thus, part of the difference in the growth of spending for post-acute care services and the growth of spending for other services is attributable to the characteristics of the beneficiaries who choose to remain in the fee-for-service sector.

**TABLE 3. SPENDING BY MEDICARE ON HOME HEALTH SERVICES,
FISCAL YEARS 1990 AND 1995**

	1990	1995	Average Annual Rate of Growth (In percent)
Outlays (Billions of dollars)	3.3	14.9	35
Outlays per User (Dollars)	1,765	4,381	20
Outlays per Visit (Dollars)	53	63	4
Memorandum:			
Number of Visits (Millions)	62.8	236.4	30
Aide Visits as a Percentage of All Visits	39.2	48.4	n.a.
Number of Users (Thousands)	1,870	3,401	12
Number of Visits per User	34	69	16
Number of Medicare Enrollees (Millions) ^a	32.8	34.7	1

SOURCES: CBO January 1997 baseline; 1996 Green Book;
Medicare National Claims History Files; and
Health Care Financing Administration, Bureau of Data Management and Strategy.

NOTE: n.a. = not applicable.

a. Excludes beneficiaries enrolled in risk-contract health maintenance organizations.

**TABLE 4. SPENDING BY MEDICARE FOR SERVICES PROVIDED BY
SKILLED NURSING FACILITIES, FISCAL YEARS 1990 AND 1995**

	1990	1995	Average Annual Rate of Growth (In percent)
Outlays (Billions of dollars)	2.8	9.1	27
Outlays per User (Dollars)	4,536	7,673	11
Outlays per Day (Dollars)	123	226	13
Memorandum:			
Number of Days (Millions)	22.9	40.3	12
Number of Users (Thousands)	617	1,186	15
Rehabilitation Charges as a Percentage of Total Charges	15.9	28.3	n.a.
Number of Days per User	37	34	-2
Number of Medicare Enrollees (Millions) ^a	32.8	34.7	1

SOURCES: CBO January 1997 baseline; 1996 Green Book;
Medicare National Claims History Files; and
Health Care Financing Administration, Bureau of Data Management and Strategy.

NOTE: n.a. = not applicable.

a. Excludes beneficiaries enrolled in risk-contract health maintenance organizations.

expenditures for ancillary services such as rehabilitation. Outlays per patient day grew by 13 percent a year, while the number of days per user actually declined somewhat over the period.

Over the past 15 years, changes in both coverage and payment policies under Medicare have contributed to the growth in the use of post-acute care services and to the major increase in the number of providers of those services. In addition to policy factors, medical advances have made it possible to provide more services in post-acute care settings. To a lesser extent, demographic changes may also affect the demand for post-acute care services.

Medicare Coverage Policies

During the 1980s, a host of legislative, regulatory, and judicial actions led to the liberalization of Medicare's coverage of home health and SNF services, increasing both the demand for and the supply of services.

The Omnibus Reconciliation Act of 1980 (ORA-80) eased several restrictions that expanded the home health benefit well beyond a post-acute care benefit. The act removed the 100-visit limit under Part A and Part B, and eliminated the requirement for a three-day hospital stay prior to the payment of home health benefits. It also

broadened the types of home health agencies that could be certified by Medicare, opening a new market for proprietary agencies.

Attempts by the Health Care Financing Administration (HCFA) to restrict the use of home health services through administrative means were ultimately overturned by the 1988 federal court decision in *Duggan v. Bowen*. Prior to the *Duggan* decision, beneficiaries could not receive frequent services on a long-term basis and, thus, many people needing chronic skilled nursing care were ruled ineligible. Subsequently, beneficiaries could receive part-time services on a daily basis. They could also qualify for benefits if they needed skilled nursing services no more frequently than once every 60 days.

While ORA-80 paved the way for the eventual expansion of the use of home health services, its effects were only realized after the *Duggan* decision. As a result of those actions, the use of home health services by Medicare beneficiaries skyrocketed after 1990.

The SNF benefit also changed but less dramatically. The Medicare Catastrophic Coverage Act of 1988 (MCCA) contained a number of changes to the SNF benefit, including the elimination of the requirement for a three-day hospital stay, changes in the copayment requirements, and expansion of coverage to 150 days in one year. Although the Congress repealed the MCCA the following year, the

number of Medicare-certified facilities, which had expanded in response to the expectation of a broader benefit, did not contract with the act's repeal.

Part of the response of the nursing home industry may have resulted from changes in Medicaid requirements that were enacted in the Omnibus Budget Reconciliation Act of 1987 (OBRA-87). That legislation eliminated the distinction between skilled nursing facilities and intermediate care facilities under Medicaid, and required all Medicaid-certified nursing facilities to meet requirements similar to the Medicare SNF requirements. Once Medicaid-certified facilities had met those new standards, it became less difficult for them to become Medicare-certified.

Because the SNF benefit retains its requirement for a three-day hospital stay, it remains in concept a post-acute care benefit. However, some Medicare beneficiaries who are also Medicaid long-term care patients may use their SNF benefits upon discharge from a hospital, even though their needs are more chronic than post-acute. States have financial incentives to ensure that Medicaid long-term care patients use Medicare SNF benefits at least for the first 20 days following a hospital discharge, because Medicare requires no cost sharing during that period. Most nursing homes may also prefer to receive Medicare payments, because Medicare rates are generally higher than Medicaid rates.

Medicare Payment Policies

Implementation of the prospective payment system (PPS) for inpatient hospital services in 1983 transformed both the hospital and the post-acute care industries. Under PPS, hospitals are given fixed payments based on the medical diagnosis of their patients rather than on the hospitals' cost of providing services. That shift from cost-based reimbursement gave hospitals an incentive to reduce their costs by discharging patients sooner into post-acute care services.

Reimbursement for post-acute care services, by contrast, continues to be on a cost basis, with Medicare paying providers more for additional services. Cost-based reimbursement has also increased the use of ancillary services, such as rehabilitation services and speech and occupational therapies.

Fixed payments under PPS, combined with separate payments for post-acute care services, have encouraged more providers to enter the post-acute care market. Between 1990 and 1995 alone, the number of SNFs grew from less than 11,000 to almost 15,000, and the number of home health agencies grew from less than 6,000 to more than 9,000 (see Table 5).⁴ A significant part of that increase in post-acute care providers is a result of hospitals establishing their own post-acute care units. In

4. The number of SNFs includes swing-bed units in hospitals.

TABLE 5. NUMBERS OF PROVIDERS OF POST-ACUTE CARE SERVICES AND PROSPECTIVE PAYMENT HOSPITALS IN MEDICARE, 1990 AND 1995

Provider	1990	1995	Average Annual Rate of Growth (In percent)
Skilled Nursing Facility ^a	10,572	14,811	7
Home Health Agency	5,718	9,147	10
Inpatient Rehabilitation Facility ^b	816	1,024	5
Long-Term Care Hospital	87	178	15
PPS Hospital	5,527	5,250	-1

SOURCES: Medicare Provider of Services File; and Health Care Financing Administration, Office of Survey and Certification.

NOTES: Counts are as of December of each year.

PPS = prospective payment system.

a. Counts include swing-bed units in hospitals.

b. Counts include PPS-exempt rehabilitation units.

1996, three-quarters of all short-term acute care hospitals had at least one post-acute unit, such as a SNF, rehabilitation unit, or home health agency. The number of freestanding proprietary home health agencies has soared as well.

Other Factors Contributing to the Growth of Spending on Post-Acute Care Services

In addition to policy changes, other factors beyond the control of policymakers--such as medical advances--contribute to the growth of spending on post-acute care services. In the longer run, demographic changes may also cause post-acute care spending to rise significantly.

Medical advances may have contributed to the growth of spending on post-acute care services, both by expanding the types of services that can be provided in less intensive settings and by creating new needs for skilled care that qualify patients for home health services. Highly technical services, such as infusion therapies and ventilator services, which until recently probably would have been delivered on an inpatient basis only, are now delivered in SNFs and in the home. At the other extreme, new drug therapies may require only a minimum amount of monitoring by a skilled nurse--perhaps a blood test once a month. That monitoring, however, could count as a skilled nursing service under Medicare, enabling a beneficiary to have access to an array of other home health services paid for by Medicare.

As the Medicare population ages, and a higher proportion of beneficiaries are in older age ranges, the demand for post-acute care services is likely to grow. Such demographic effects are important contributors to the long-run growth of spending on post-acute care services but played only a minor role in the explosive growth of spending between 1990 and 1995.

POLICY OPTIONS

The rapid growth of Medicare spending on post-acute care services contributes substantially to the financing problems facing Medicare, as well as to the imbalance of payments and revenues in the HI trust fund that will soon lead to that fund's depletion. Policy options that would reduce the growth of post-acute care spending vary in their budgetary effectiveness, feasibility of rapid implementation, impact on the quality of care available to beneficiaries, and likely acceptance by providers.

Tighten Current Payment Systems

Perhaps the simplest policy option would be to tighten, rather than replace, the current payment systems for home health, SNF, rehabilitation, and other institutional services paid under HI. Each of those services is paid on a cost-reimbursement basis,

subject to a limit. Those limits could be reduced, or they could be imposed where particular costs (such as ancillary services in SNFs) are not now subject to a limit (see Box 2). That approach could be useful in the short run, especially if more fundamental reforms are not yet ready for implementation. Although tightening limits on cost-based reimbursement would yield Medicare savings, such a policy would not address the financial incentives that have driven the growth in the volume of post-acute care services in recent years.⁵

Tighten Current Coverage Standards

Another approach to slowing the growth of spending on post-acute care services would be to tighten coverage standards for those services, particularly the home health benefit. The expansion of home health care during the 1980s from a limited post-acute care benefit to a broad benefit with unlimited visits, as it is today, has substantially increased the number of beneficiaries and the volume of services used; it has also changed the nature of those services. In addition to medical and support services following acute illness, Medicare home health services now provide chronically ill beneficiaries with extensive assistance, on a long-term basis, with the activities of daily living.

5. Tightening limits on cost-based reimbursement would, moreover, have a disproportionate effect on those home health agencies whose costs are already above the limits.

BOX 2.
MEDICARE'S SKILLED NURSING
AND HOME HEALTH BENEFITS

Services provided by skilled nursing facilities (SNFs) and home health agencies account for most Hospital Insurance (HI) payments to providers of post-acute care services--roughly five-sixths of the total in 1995. Aspects of Medicare's coverage and payment policies account for much of the rapid growth in spending for those two benefits.

SNF Benefit. Medicare pays for up to 100 days of SNF care during a spell of illness for beneficiaries who recently have completed a minimum three-day hospital stay and need skilled nursing or rehabilitation services on a daily basis. A copayment equal to one-eighth of the hospital inpatient deductible is required from the beneficiary, beginning on the twenty-first day of SNF care. That copayment is \$96.50 in 1997.

Medicare pays SNFs separate amounts for routine services, capital costs, and ancillary services. Payments for routine services (which include room, board, and skilled nursing services) are based on facility-specific costs subject to national limits. Payments for capital and for ancillary services (such as physical therapy, occupational therapy, speech therapy, laboratory tests, and radiological procedures) are based on the facility-specific costs without limits.

Home Health Benefit. To qualify for the home health benefit, enrollees must be homebound and require skilled nursing care or physical or speech therapy on a part-time or intermittent basis. Beneficiaries may also receive occupational therapy home health aide services, or medical social services. A prior hospital stay is not required to receive the home health benefit. Medicare pays for these services in full, with agency costs limited by a percentage of national average costs per visit.

Under these circumstances, there is little objective information on which to decide which services should be covered or to assess the value of different courses of treatment. Undoubtedly, Medicare pays for some services whose value to certain beneficiaries is less than the program's cost of providing them. Identifying those cases is difficult, however, and creating a national coverage rule may be impossible. A less subtle approach, reverting to the narrower coverage that existed before 1980, would reduce spending for this benefit, although it might also remove coverage for many chronically ill patients who now depend on home health care. Not all the potential savings would be realized, however, if the home health industry responded to tighter coverage standards by seeking out new beneficiaries to serve.

Tightening national coverage standards would be a top-down approach to reducing unnecessary spending on post-acute care services, and that approach would be contentious. An alternative to modifying existing rules for payment and coverage would be to change the financial incentives facing beneficiaries and providers, making them more inclined to curb their use of services and control costs.

Change Financial Incentives for Beneficiaries

Beneficiaries, at least in principle, have incentives to limit their use of health care services if they face some form of cost sharing when they receive those services.

Although most Medicare acute care services have cost-sharing requirements, the major post-acute care services are wholly or partially exempt. Home health services have no cost-sharing requirements at all, and the first 20 days of SNF care are also exempt. After that initial period, however, a substantial copayment is required for SNF services.

Beneficiaries' use of services would probably not decline substantially if cost-sharing requirements were expanded, because the effects of cost sharing in the Medicare program have largely been dampened by widespread private and public supplemental coverage. That coverage typically pays for Medicare's cost-sharing requirements, reducing the incentives for beneficiaries to curb their utilization. Without prohibiting supplemental policies from covering Medicare cost sharing, greater cost-sharing requirements would be unlikely to induce most Medicare beneficiaries to use fewer services.

Nonetheless, expanding cost-sharing requirements would produce substantial program savings even without restructuring Medicare supplements, since some of the cost of services would be shifted to beneficiaries. A 10 percent coinsurance requirement on the home health benefit, for example, might have reduced Medicare payments by as much as \$1.7 billion in 1996, even if there was no reduction in the services used by beneficiaries. Part of the Medicare savings would be offset by

higher Medicaid expenditures, however, because Medicaid pays the Medicare cost-sharing amounts for about 5 million low-income Medicare beneficiaries.

Change Financial Incentives for Providers

Providers who are placed at financial risk for the services that they either provide directly or order for patients are much more likely to be sensitive to the cost of those services. That fundamental premise underlies the structure of health maintenance organizations (HMOs). An HMO receives a fixed capitation payment for each enrollee and must provide all the services that a patient may need for that fixed amount. The health plan profits if it can provide care at a cost per person that is lower than the capitation payment, and if it cannot do so, it must absorb any losses (subject to any reinsurance it may have). The financial incentive for the plan is, therefore, to reduce costs, either through reductions in service or increases in efficiency. Two policy options--prospective payment and bundling--have been proposed that would adapt some of the incentives of a capitation payment to post-acute care services in fee-for-service Medicare.

Prospective Payment Systems for SNF and Home Health. One widely discussed policy option would replace current cost-based reimbursement systems for SNF and home health services with separate prospective payment systems. Prospective

payment could be established for services provided per SNF day or per home health visit, or for services provided over an entire episode of SNF or home health care. An episode could, for example, be an uninterrupted stay in a SNF, or home health services provided on a regular basis for a certain time period (for example, until there was a break in service of 60 days). Providers would have incentives to reduce their costs for whatever unit of service was covered by the payment.

In principle, per-episode prospective payment systems would be more likely to lower spending growth than per-day and per-visit approaches, because providers would receive the same payment amount regardless of the number of services they provided in a given episode. By contrast, under per-day or per-visit payment systems, providers would receive higher reimbursements if they provided more days of care or more visits during an episode. Such a system would allow home health agencies, for example, to increase revenues by reducing the services provided during a visit, necessitating more home health visits. Per-episode prospective payment systems, however, would carry some risk that providers would seek out low-cost beneficiaries with few post-acute care needs, thereby capturing a full payment amount at little cost to themselves. A case-mix system, to modify payment according to the beneficiary's need for services, would be necessary to avoid such a problem. Without adequate safeguards, per-episode prospective payment systems might substantially increase spending on post-acute care services by increasing the number of episodes.

Bundling of Post-Acute Care Services. The bundling approach would extend prospective payment to a larger set of acute and post-acute services. In a typical bundling scheme, hospitals would be paid a single prospective payment for both inpatient care and some amount of post-acute care services (typically all services provided within 60 days of discharge from the hospital). Those services might include SNF and home health care, and both inpatient and outpatient rehabilitation services. The broader the package of services covered by a bundled payment, the more effective such policies would be in reducing Medicare costs.

Hospitals would bear the financial risk for the patient's treatment over the episode of care and would be responsible for providing or contracting for any necessary post-acute care services. Medicare would not make separate payments to individual providers for services provided under the bundled payment.

Bundling Versus Separate Prospective Payment Systems. The inducement for providers to curb both acute and post-acute care spending would be considerably greater under a bundled payment than under separate prospective payment systems for SNF and home health. The hospital receiving a bundled payment would have a strong incentive to place patients in the most cost-effective settings throughout the acute and post-acute periods, and to avoid discharging them too quickly into a post-acute care setting, if staying in the hospital would be the least costly option. Instead, the bundled payment would discourage the overall use of services. The possibility

of expanding the number of bundled episodes would be limited, however, because an inpatient stay would be required to trigger payment.

By contrast, under separate prospective payment systems, providers would have incentives to increase the number of beneficiaries using each type of service in order to capture each prospective payment. Once a patient was admitted to a particular service, however, providers would benefit financially by discharging them to another provider as soon as possible. Thus, one would anticipate a considerable amount of patient "churning" under separate prospective payment systems, with patients moving from inpatient hospital care to SNFs and then to home health.

A bundled payment policy holds considerable promise for slowing the growth of Medicare spending for post-acute care services following an inpatient stay, which constitutes most of Medicare spending on such services. But that policy does not address the use of home health services that are of a chronic nature and would therefore not be part of a post-acute care bundle. Those services account for a growing share of Medicare home health spending. Under current use patterns, probably no more than one-third of Medicare home health visits would be part of a post-acute care bundle.

A range of alternative payment and coverage policies might slow the growth of spending for home health visits that were not part of the post-acute care bundle.

Those policies include:

- o Instituting cost-sharing requirements for home health services outside the bundle;
- o Continuing with the current reimbursement system for those types of visits only, but using much tighter cost limits;
- o Reducing payment levels through a separate prospective payment system for home health episodes outside the bundle;
- o Placing limits on the total number of home health visits that could be separately reimbursed in any episode of care; or
- o Making more fundamental changes to Medicare's coverage policies-- for example, by restricting the home health benefit to post-acute care services only.

The pros and cons of those options were discussed earlier. None of the three payment options would be likely to reduce the growing volume of home health

services. Payment reductions and cost sharing could, however, yield some program savings. Reductions in Medicare coverage would be more effective in reducing program costs, but the increased financial burden of such reductions on chronically ill patients and on Medicaid could be significant.

ISSUES IN ESTABLISHING A POST-ACUTE CARE BUNDLING POLICY

Any major payment reform for post-acute care services would require policy decisions regarding the scope of services covered by the new payment system, the payment amount, how the payment might vary according to the needs of the patient, and cost-sharing requirements. A new payment system would also raise concerns about the effects of that system on the quality of care and patient choice, as well as on the structure of the market. This discussion focuses on those issues and the strategies that Medicare might use to phase in a post-acute care bundling policy.

Definition of the Service Bundle

Under a bundling policy, providers would receive a fixed payment to cover a certain range of services for an episode of care. To define the bundle, therefore, one has to specify the services that would be included and how an episode would be determined.

Services Included in the Bundle. Analysts have suggested three broad criteria for including services in a post-acute care bundle: the services should be clinically related to the hospital admission; they should account for a large or rapidly growing share of spending in the post-acute period; and they should be potential substitutes for each other.

Using those criteria, certain services--SNF, home health, and inpatient rehabilitation--are obvious candidates for inclusion in the bundle. But the extent to which other services should be incorporated is less clear and would depend, in part, on the possible behavioral responses of providers to a bundling policy. Long-term care hospital services, for example, are apparently used by only a small fraction of Medicare discharges from short-term hospitals.⁶ If those services were excluded from the bundle, however, hospitals receiving bundled payments would have incentives to transfer patients to long-term care hospitals.

The bundle might also include a variety of services that are currently reimbursed under Medicare Part B--the most important being outpatient rehabilitation services. Those services are clear substitutes for some services that are provided by SNFs and home health agencies, as well as for inpatient rehabilitation services. In addition, an argument could be made for including such services as

6. In 1994, 0.2 percent of Medicare discharges used long-term care hospital services within 30 days of discharge.

durable medical equipment and oxygen, which, if used during the post-acute period, are very likely related to post-acute needs.

Definition of an Episode. Ideally, the bundle of services would include all services provided in the acute and post-acute periods for a given episode of illness. The most practical option for defining an episode of care under a bundling policy would be to use a fixed time period following either admission to or discharge from the hospital. Starting the period from the date of discharge, rather than the date of admission, would probably be preferable because the length of an inpatient stay varies substantially and is related to the severity of the patient's condition on admission.

The appropriate time period to be covered after a hospital discharge determines how inclusive the bundled payment would be. In general, shorter periods would be more likely to capture only true post-acute care spending, but they would also be more likely to result in Medicare's making additional payments for post-acute care services that fall outside the bundling period. Longer periods would involve greater risks for providers, who might have to pick up more unrelated costs. A recent study indicates that average post-acute care spending falls off markedly after 60 days post-discharge, even among diverse diagnoses, suggesting that 60 days might be a reasonable bundling period.⁷

7. A. James Lee, Randall P. Ellis, and Angela R. Merrill, "Bundling Post-Acute Care (PAC) with Medicare DRG Payments: An Exploration of the Distributional and Risk Consequences," *Inquiry*, vol. 33 (Fall 1996), pp. 283-291.

A typical proposal might, therefore, define the episode as up to 60 days from the date of discharge. The hospital would have to use the bundle amount to pay for any services that were both part of the bundle and provided during that 60-day window. To minimize the problem of hospitals paying for care unrelated to the original hospital admission, an exceptions policy could be developed.

Determination of Payment Amounts

Fee-for-service Medicare currently pays hospitals a fixed amount for the acute care of patients in each diagnosis-related group (DRG), the basis of hospital PPS. If hospitals became responsible for post-acute care services, policymakers would have to decide the base amount of the bundled payment, as well as how to adjust that base payment over time and to reflect variations in patient care needs, regional variations in input costs, and other factors.

Establishing the Basic Payment Policy. Separate bundled payment amounts would almost certainly need to be established for each DRG, allowing payments to reflect the variation of post-acute care spending among DRGs. Because there have been so few curbs on post-acute care spending, however, using recent spending data to estimate an add-on to each DRG payment could result in payments to providers that would be considerably higher than their subsequent average costs. A possible

solution would be to reduce the estimated add-on for each DRG by a certain percentage, or to rebase the payment amounts in the early years of the policy to reflect the changes in utilization that the policy would invoke. But rebasing would require that providers continue to provide information on service use through some modification of the current cost-reporting system.

Case-Mix Adjustment. Any prospective payment approach has incentives for providers to reduce the costs of the services that they provide. Lower costs might be achieved through greater efficiency, but they might also result in reduced services for beneficiaries or access problems for costly patients. Case-mix measures would adjust payment rates to reflect the expected resource use of different categories of patients, much as the DRG system today uses patients' diagnoses to adjust payments for inpatient hospital services. Such measures would reduce payment incentives that lead providers to reduce appropriate services or to seek out low-cost patients only.

A case-mix measure for a bundle of acute and post-acute care services could be developed based on DRGs because at least three-quarters of the bundled payment would generally be accounted for by the inpatient service. Moreover, post-acute care expenditures are heavily concentrated in a few DRGs; half of the Medicare hospital patients who are discharged to post-acute care services are in only 15 DRGs. Accurately predicting the cost of a bundled episode of care would require modifying the DRGs, however, to reflect variations in the social, functional, and medical needs

of Medicare beneficiaries. Over the past decade, the Health Care Financing Administration has sponsored research on case-mix measures for post-acute care services, but considerably more research is needed.

Adjustments for Geographic Differences in Costs. Bundled payments would need to be adjusted to reflect geographic differences in input prices, perhaps similar to the adjustments that Medicare makes in determining hospital PPS payments. Those payments are based on national standardized payment amounts that are higher for hospitals in large metropolitan statistical areas (MSAs). To reflect local input prices, those amounts are then adjusted by a wage index for each MSA and for the rural areas in each state.

Treatment of Outliers. Even if an effective case-mix adjuster could be developed, some patients would require much more extensive and costly post-acute care services during the bundling period than the average for the group in which they were classified. Some of those costs would appropriately be absorbed by hospitals, which would benefit financially when they served patients with lower-than-average costs. But a stop-loss policy, perhaps in the form of additional payments, would probably be necessary to ensure that very costly patients continued to have access to appropriate services during the bundling period. Such a policy could be based on the current cost-outlier policy used in PPS.

Treatment of Readmissions. A policy would also be needed to determine whether a new bundled payment would be triggered if a patient was readmitted to a hospital--either the hospital initially admitting the patient or another hospital. If a readmission during the bundling period automatically started a new episode of care, providers would have perverse incentives to readmit patients to a hospital, thereby capturing a second bundled payment. However, some readmissions would be appropriate and should be expected during a 60-day post-discharge window; a patient discharged with a cardiac diagnosis could subsequently fall and sustain a fracture, for example.

Under the PPS system, if a Medicare patient discharged from a hospital is subsequently readmitted, the first hospital must demonstrate that the patient was not discharged prematurely. Otherwise, its PPS payment is denied. Similar mechanisms could presumably be used under a bundling policy.

Beneficiary Cost Sharing

Current Medicare cost-sharing requirements vary considerably among services. Inpatient hospital services, for example, have an initial deductible and coinsurance requirements commencing after 60 days. SNF services have no cost-sharing requirements for the first 20 days, after which hefty daily coinsurance rates (one-eighth of the inpatient hospital deductible) commence. Home health services have

no cost-sharing requirements at all, and coinsurance rates for outpatient rehabilitation services are 20 percent of covered charges.

Because cost sharing lowers Medicare outlays, regardless of its effects on service use, continuing some form of cost sharing under a bundling policy would be appropriate. To maintain the current cost-sharing structure, hospitals and SNFs would need to report the use of services, much as they do now. Alternatively, cost-sharing for bundled services could be simplified by eliminating SNF and hospital coinsurance and increasing the hospital deductible in a budget-neutral way. Such an approach would be consistent with the underlying goal of a bundling policy--that is, to induce providers to make placement decisions based on the cost-effectiveness of different services rather than on their reimbursement rates.

A simple deductible approach might, however, raise some concerns about fairness. The majority of Medicare beneficiaries who are discharged from hospitals use no post-acute care services at all. If the current inpatient deductible was raised to reflect the additional services included in the bundle, those beneficiaries would pay higher deductibles for services that they would not use.

Quality of Care and Patients' Choice

Bundling would affect providers' financial incentives in several ways, some of which might result in improvements in the quality of care while others might be detrimental. The bundled payment would increase incentives for efficiency and give hospitals--assuming that they were the recipients of that payment--the flexibility to place patients in the most cost-effective settings.

Hospitals would have a powerful case management role, because they would control the flow of dollars as well as managing the care of patients. Effective case management, covering the spectrum of inpatient and post-acute care services, could reduce service fragmentation and enhance the quality of care received by Medicare beneficiaries. But the incentives for providers to reduce the use of all services would increase, and providers might cut back on the use of both appropriate and inappropriate services.

In addition, some providers of post-acute care have voiced concern that hospitals lack the experience to manage a patient's care beyond the hospital stay. Nonetheless, some hospitals are presumably performing such functions now, because many of them have their own home health agencies and SNFs or are members of networks that include those services.

A closely related concern is the effect that bundling policies would have on beneficiaries' choice of providers. Hospitals would have a strong interest in providing services themselves, providing them through provider networks in which they participate, contracting with cost-effective providers, or using some combination of those strategies. Although hospitals currently have a large impact on beneficiaries' choice of post-acute care providers through the discharge planning process, a bundling policy would almost certainly restrict that choice. Federal oversight to ensure that quality was maintained would be essential. An appeals process might be an appropriate way to deal with disputes between beneficiaries and hospitals regarding who should provide post-acute care, but such a process would be ineffective if it did not yield extremely rapid resolution to patients' complaints.

Market Structure

Under a bundling policy, hospitals would either provide post-acute care services themselves or contract with other providers for those services. Some concerns arise--especially with rural hospitals--about the feasibility of implementing such a policy nationwide. Isolated hospitals, for example, might have little choice of post-acute care providers with whom to contract, placing them in a difficult situation for bearing full financial risk for post-acute care services.

The recent dramatic growth in the number of providers of post-acute care services nationwide substantially mitigates that potential problem. As already noted, three-quarters of hospitals already own at least one post-acute care service, and rural hospitals actually have a higher rate of ownership of post-acute care services than urban hospitals. Urban post-acute care markets are generally competitive, with virtually all metropolitan areas having at least three SNFs and most having at least three home health agencies. Because of the difficulties in delineating geographic markets in rural areas, the competitiveness of those markets is less clear. Moreover, rural hospitals seeking to establish their own post-acute care services might face barriers from certificate-of-need laws. But because many rural hospitals are flagships of their communities, experts believe that they could probably obtain the necessary approvals to establish post-acute care services.

With hospitals receiving and managing the bundled payments, the nature of the post-acute care industry would fundamentally change. In spite of the growth of the hospital-based sector, providers of post-acute care services are predominantly freestanding. Those providers would now have to contract formally with hospitals and with each other, requiring a much greater degree of coordination than now exists. In markets with large numbers of post-acute care providers, some providers might find it difficult to obtain contracts from hospitals. Under those circumstances, some home health agencies might concentrate on serving only patients requiring chronic care.

Transition to a Bundled Payment System

Shifting to a bundled payment system would involve a major restructuring of the post-acute care industry. Such a significant change might need to be planned and phased in over several years in order to ensure a smooth transition and to avoid disruptions of services for Medicare beneficiaries.

Options that could be implemented initially to provide a transition include applying bundled payment to a limited number of DRGs, having a limited number of post-acute care services in the bundle, or paying a blend of the bundled payment and fee-for-service payment. Those interim options would, however, dilute the incentives toward cost reduction offered by the full bundling policy.

A more complex option would allow hospitals to accept a bundled payment voluntarily or to remain under an unbundled payment system that imposed a volume performance standard on post-acute care services. Such an approach could counteract the volume-increasing aspects of the previous interim options. In addition, the transition from provider-specific payments to national rates could be phased in.

Phasing In Covered DRGs. One way to phase in a bundled system would be to start with a limited number of DRGs--for example, those that account for the majority of the spending on post-acute care services that occurs after an acute care episode. By concentrating planning and design efforts on those DRGs one could, in theory, establish a system relatively quickly that would have a significant impact on spending. That approach, however, would encourage providers to reclassify patients into other DRGs excluded from the bundling policy, if they would be reimbursed more by so doing. Such an incentive already exists in the PPS system, but in recent years that kind of coding reclassification has increased payments to hospitals only modestly. A careful selection of DRGs for the transitional bundled payment could mitigate the effects of upcoding.

Phasing In Covered Services. Another way to phase in bundling would be to confine the bundle to a limited number of post-acute care services. For example, one could define the initial bundle to include institutional care only--that is, hospital, SNF, and institutional rehabilitation services (which may be close substitutes), but not home health services. Such an approach would be simpler to implement than a policy that included home health, and hospitals would have fewer providers with whom to negotiate during the transition. But excluding home health services from the bundled payment would give providers incentives to shift patients from institutional post-acute care to home health care. If home health services are relatively poor substitutes for institutional care, the incentives to control the volume of post-acute care services

would be greater under this interim option than the current payment system, but weaker than under full bundling.

Phasing Out Fee-for-Service Rates. An interim system might use some form of blended payment to ensure access to care for high-cost patients. Hospitals could, for example, be paid for post-acute care services, with half of that payment being prospective and the other half based on the post-acute care services that they actually provided. (They would also receive the full DRG payment for inpatient services.) Hospitals that used more post-acute care services regardless of the needs of patients would be penalized less than otherwise, but so would providers whose patients had social and functional needs not recognized by DRGs. A hospital serving primarily low-income patients in the inner city, for example, would expect to provide more post-acute care services than a hospital serving middle-class patients in the suburbs. (In addition, the disproportionate share payments now made by Medicare to such hospitals could be extended to payment for post-acute care services.) But increases in the use of home health services could be substantial under this option if half of the Medicare fee-for-service payment exceeded the cost of an additional visit by a nurse or an aide.

Establishing a System of "Hospital Preferred Providers" and Volume Performance Standards. Medicare could allow hospitals to accept a bundled payment for acute and post-acute care services voluntarily, enabling them to become "hospital preferred

providers." Such hospitals might also be permitted to charge lower deductibles than others not participating in this program. As hospitals that were preferred providers gained experience with bundled payments, other hospitals might develop the provider networks needed to compete effectively in this system.

Hospitals not choosing the bundled payment could be held more accountable for the post-acute care costs that their Medicare patients incurred during the post-discharge period covered by the bundled payment. For example, a post-acute care volume performance standard (VPS), similar in concept to Medicare's VPS for physicians, could be instituted. The VPS could be set to reduce or eliminate increases in Medicare spending that might result from the voluntary participation of the lowest-cost providers in the bundled payment system. But to ensure savings during the transition, the VPS might have to be extremely stringent, possibly creating difficulties for providers of post-acute care services serving disproportionate numbers of costly patients.

Phasing In National Rates. A bundling policy could adopt an approach to phasing in national rates that was similar to the one used under the PPS system. During a transition period lasting several years, hospital payments shifted from the purely hospital-specific rates that existed before PPS to national rates. If such a transitional approach was used with post-acute care bundling, only the payment for post-acute care services would be adjusted from a provider-specific payment to a national rate.

The transitional payment would be based on historical cost data and determined prospectively. That policy would benefit hospitals with historically high post-acute care costs, but would still give incentives to curb spending on post-acute care services.